CHILDREN'S SPECIAL HEALTH CARE SERVICES

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MISSION STATEMENT

The Children's Special Health Care Services (CSHCS) program provides financial assistance for needed medical treatment to children with serious and chronic medical conditions to reduce complications and promote maximum quality of life.

GENERAL INFORMATION

Welcome to the CSHCS Program! This manual defines services and responsibilities for participants (newborn to 21 years of age or individuals with Cystic Fibrosis for lifetime), their families (parents, legal guardians, foster care providers), and medical providers (physicians, dentists, therapists, pharmacies, hospitals, clinics, suppliers).

The CSHCS Program financially assists families for the medical care of chronically ill children with special needs. Participants approved for the program must meet financial and medical guidelines. The program pays for all appropriate authorized care relating to an eligible diagnosis. CSHCS pays only after all other sources of payment are exhausted.

CSHCS is not a Medicaid program. CSHCS is a separate program (formerly known as the Indiana Crippled Children's Program) administered by the Indiana State Department of Health (ISDH). CSHCS pays medical providers at the maximum allowable Medicaid rate and uses Medicaid coding and claim forms.

The CSHCS office provides Care Coordination, Eligibility, Prior Authorization (PA), Claims Processing, Provider Relations, and Travel Reimbursement support services for providers and participants or their families at (800) 475-1355 (In-State only) or (317) 233-1258. Participants and providers must report changes such as address, telephone numbers, or corporate or individual names to CSHCS to ensure coverage and timely claims payment.

SERVICES

The CSHCS program links all participants to a primary, specialty, and dental provider:

- Each participant must have a Primary Care Provider (PCP). The PCP is a doctor or clinic providing routine care such as a physical examination, immunizations, or "sick child" visit in an office setting.
- Each participant may have a Specialty Care Provider (SCP). The SCP provider is a doctor or clinic providing specialty care for the participant's eligible medical diagnosis. The PCP and SCP may be the same provider.
- Each participant may have a Dental Care Provider (DCP). The DCP is a dentist or clinic providing routine dental care to keep the participant's teeth and gums healthy.
- The CSHCS Program provides specialty dental care to treat a participant's eligible medical diagnosis such as cleft lip and palate.
- CSHCS pays for lab work, x-rays, and prescription medicines. These services need not relate to the participant's eligible diagnosis or require prior authorization, but the participant's PCP, SCP, DCP, or specialty dental provider must prescribe these services.
- CSHCS may pay for some over-the-counter (OTC) vitamins, formula, and supplies with PA that treat an eligible diagnosis.
- CSHCS pays for some travel to and from providers under State Travel and CSHCS rules.

SERVICE LIMITS

These are some examples of service limits. The PA Unit assists with unusual circumstances:

- Most equipment is limited to one item.
- "Back-up" equipment is not covered.

- Some replacement equipment is limited to once within five years.
- Specialty care must relate to the participant's eligible medical diagnosis.

EXCLUSIONS

CSHCS does not cover all services such as these:

- Over-the-counter (OTC) drugs such as Tylenol and cough syrup, even with a prescription.
- OTC supplies such as diapers, non-sterile gloves, alcohol, tape, bleach, Band-Aids.
- Mental health services, counseling, testing, therapy, except with PA, substance abuse treatment.
- Prenatal care or other pregnancy-related care.
- Emergency room visits not related to the participant's eligible diagnosis such as an emergency room visit for a broken arm and a CSHCS qualifying diagnosis of asthma.
- Hospitalization not related to the eligible diagnosis.
- Organ transplants.
- Eyeglasses, if not related to the eligible diagnosis.
- Earplugs.
- Egg crate mattress covers.
- Communication boards or devices.

PROVIDERS

Participants must be sure their providers are CSHCS providers before making appointments. CSHCS cannot assist participants with bills from providers not enrolled in CSHCS, and participants are responsible for those bills. CSHCS will assist both families and providers with enrolling in the program. Providers must have a signed "provider

agreement" with CSHCS for legal purposes and under the terms of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

PRIOR AUTHORIZATION (PA)

A CSHCS PA confirms medical necessity and its relationship to a CSHCS eligible diagnosis. A CSHCS PA does not guarantee payment by CSHCS.

All CSHCS services must have CSHCS PA. Accepting or providing services before securing PA causes claim denial except in an emergency. These are examples of services requiring PA:

- Initial authorization for primary, specialty, routine and specialty dental care. Further authorization is not necessary for "in-office" services.
- In-patient services (hospitalizations).
- Equipment and supplies.
- Surgery.
- Specialty dental services.
- Therapy.
- Home health care.
- Referral to other physicians or providers.
- Emergency Room Services.

Providers must secure CSHCS PA for participants or their families enrolled in CSHCS. CSHCS cannot pay for services denied by private insurance because the provider did not obtain PA or prior certification (PC). CSHCS cannot pay for services denied by Hoosier Healtwise, or Medicaid because the provider did not obtain PA. Providers may not bill participants or their families if the provider did not secure PA or PC.

CSHCS may consider a PA for unusual circumstances of service out-side of insurance, HMO, PPO, Hoosier Healthwise or Medicaid provider groups or procedure. Strong and

compelling documentation of proper appeal, medical necessity, continuity of service, economy, and financial consequence to providers, families, and the program must support exceptions.

Participants must notify the CSHCS program of emergency care or emergency hospitalizations within five working days of the visit. CSHCS PA requires a mailed or faxed discharge summary or medical notes from the emergency room visit. The provider is responsible for obtaining and sending these documents to CSHCS. CSHCS authorizes only services related to an eligible medical condition.

PAYER OF LAST RESORT

The CSHCS program is the payer of last resort. CSHCS considers claims after insurance, HMO, PPO, or Medicaid payments. The provider must accept insurance payments made at or above the Medicaid rate as "payment in full" for an eligible CSHCS service. Providers may not bill participants or their families for an unpaid balance after CSHCS adjudication.

Families and providers must use all available private insurance (HMO, PPO, BC/BS, Travelers, etc.) or public resources (Hoosier Healthwise or Medicaid) before billing CSHCS. Participants or their families must report all changes or loss of private or public coverage to CSHCS and providers as soon as possible.

A participant's failure to report changes to CSHCS and providers can make the participant responsible for the cost of service. Participants or their families must follow the procedures of their insurance company, HMO, PPO, Hoosier Healthwise or Medicaid such as securing PA or PC, visiting only network providers, or outside referrals. Insurance company service representatives and HMO, PPO, Hoosier Healthwise and Medicaid caseworkers can assist providers and participants or their families in following procedure. CSHCS encourages participants or their families to contact and verify CSHCS PA for services with CSHCS and their providers. Providers are responsible for securing CSHCS, Hoosier Healthwise and Medicaid PA as the entity receiving payment

for services. CSHCS does not pay participants or their families directly except for travel reimbursement.

MEDICAID

Medicaid pays before CSHCS.

Participants must apply for Medicaid when applying for CSHCS and enroll in Medicaid if eligible to qualify for CSHCS. Participants or their families must report Medicaid enrollment to medical providers and CSHCS including identification number, effective date, and any changes to providers and CSHCS. Participants or their families enrolled in Hoosier Healthwise or Medicaid must see Medicaid providers and follow Hoosier Healthwise or Medicaid guidelines.

Providers may contact the CSHCS PA Unit for consideration of coverage if Medicaid denies a PA request. CSHCS will consider paying claims denied by Medicaid on a case-by-case basis.

APPEALS

CSHCS may ask a participant to appeal a denial by an insurance company, HMO, PPO, or Medicaid of services the participant, provider, or CSHCS consider necessary and allowed. Providers must cooperate with a participant's request for necessary information. CSHCS will not consider authorizing and paying for services until the appeal process is complete and documentation received by CSHCS.

DEDUCTIBLES, CO-PAYMENTS & MEDICAID SPEND-DOWN

CSHCS may cover the insurance deductibles, co-payments, and Medicaid "spend-down." CSHCS will pay co-payments up to $25. CSHCS pays charges applied to the participant's insurance deductible at Medicaid rates. CSHCS deducts amounts paid by the insurance company from the Medicaid rate. This may result in no CSHCS payment if insurance pays more than the Medicaid rate. If this occurs, the provider may not bill the participant for the unpaid balance or deductible.

PAYMENT

CSHCS pays at Indiana Medicaid rates. Providers must submit claims within one year of service. If primary insurance pays more than the Medicaid rate, the provider must accept this as payment in full. Under the terms of the provider agreement, the provider may not bill the participant for the difference between the billed amount and the Medicaid rate.

ISDH mails checks to providers with an Explanation of Payment (EOP). The EOP details information such as payments exceeding the Medicaid rate or reasons for denial.

RE-EVALUATIONS

CSHCS re-evaluates participants once a year by mail to maintain active status. During re-evaluation, participants must update income status, insurance information, household members, and other changes. Participants should provide changes as they occur to speed the annual process.

CASE CLOSURE

Case closures occur for various reasons:

- Failure to complete and return the annual re-evaluation form within the allotted time.
- Failure to provide updated income information.
- The participant reaches the age of 21 years.
- Failure to use health insurance.